

JANE DEE HULL
GOVERNOR



CHARLES R. COHEN
DIRECTOR

ARIZONA DEPARTMENT OF INSURANCE

2910 North 44th Street, Second Floor, Phoenix, Arizona 85018-7256 · (602) 912-8456 · FAX: (602) 912-8452

Circular Letter 2000-13

To: **All Health Care Insurers, Health Care Services Organizations, Hospital Service Corporations, Prepaid Dental Plan Organizations, Medical Service Corporations, Dental Service Corporations, Optometric Service Corporations, Utilization Review Agents, Insurance Trade Associations And Interested Parties**

From: **Charles R. Cohen
Director of Insurance**

Date: **October 16, 2000**

Re: **Health Care Appeals Laws Revisions from HB 2600 and SB 1330**

This Circular Letter addresses procedural changes in the health care appeals process, and should be read together with Circular Letter 2000-6, issued May 17, 2000¹ for a complete understanding of all the changes to Arizona's health care appeal laws. This Circular Letter also includes the standardized health care appeals forms that are to be included with health care appeals packets, a revised health care appeals packet to guide insurers in developing their own packets, and a revised transmittal form that insurers must use when sending the Department a request for external independent review.

I. EFFECTIVE DATES

Both HB 2600 and SB 1330 amended the health care appeals process. SB 1330 actually amended amendments made in HB 2600. This resulted in a complicated series of effective dates. The changes described in this circular are effective March 1, 2001 unless a different date is specified.

II. APPLICABILITY

The health care appeals laws expressly apply to the activities of **all** health care insurers and utilization review agents ("UR agents"), and **are not** limited to just the activities of Health Care Services Organizations (HMOs). (See A.R.S. §20-2531(A); see also, Circular letter 1999-3, "Compliance With Arizona's Health Care Appeals Laws.")

¹ This circular letter focuses on changes in the appeals process (new requirements and elimination of old requirements). It does not explain terminology that was already defined in the bills or explained in prior circulars, and should not be treated as an exhaustive description of all steps or requirements in the process. This circular letter and past circular letters are available on the Department's web site at www.state.az.us/id.

Effective **July 18, 2000**, long-term care insurance, Medicare supplement insurance, and multi-employer benefit plans created under 29 U.S.C. §186(c) have been added to the exceptions listed in A.R.S. §20-2531(C), and are no longer subject to the appeals process.

III. PROCEDURAL AND ADMINISTRATIVE ISSUES

Utilization Review & Written Denials (Effective January 1, 2001)

There are new requirements for denials based on medical necessity. When an insurer or its UR agent denies authorization for a service based on lack of medical necessity, a medical director with an active, unrestricted license under 32 A.R.S. Chapter 13 or 17 (i.e. an *Arizona-licensed* M.D. or a D.O.) must issue and sign a written denial explaining why authorization was denied. A.R.S. 20-2510(B). Insurers that cover only dental care may substitute an Arizona dentist licensed under 32 A.R.S. Ch. 11 for the M.D. or D.O. Insurers that cover only optometric care may substitute an Arizona optometrist licensed under 32 A.R.S. Ch. 16. A.R.S. 20-2510(C).

The insurer must send a copy of the written denial to the treating provider and maintain copies of all denials for Department inspection. A.R.S. 20-2510(B). The Department recommends that insurers maintain copies for at least 3 years following the later of the date of denial or any final appeal decision arising from that denial.

Notice Requirements

At the time of issuing a denial, insurers must also notify insureds of the right to appeal the denial. (A.R.S. §20-2533(D).) Insurers that issue an explanation of benefits (EOB) must prominently display a statement about the right to appeal on the EOB form. If an insurer does not issue an EOB, it must find some other reasonable means to advise the insured of the right to appeal. An insurer may satisfy this obligation by giving a form statement about the right to appeal to the insured's treating provider, who must then notify the insured of the right to appeal. An insurer that intends to have the treating provider notify insureds of appeal rights must incorporate this duty into its provider contracts as an express obligation.

The goal of this new requirement is to alert an insured that he or she may challenge certain insurer decisions with which the insured disagrees, at the very time the insured is most aware of and affected by the decision. This requirement recognizes that insureds may not retain information provided at open enrollment or policy renewal, and may not remember that Arizona has an appeals process. This consideration will guide the Department in assessing whether an insurer has used reasonable means to give notice.

Information Packets on the Appeals Process

Insurers are generally required to send their insureds an information packet on the appeals process.² The packets must contain the information listed in A.R.S. §20-2533(C). The new law requires insurers to add new information to the packet, and to provide the packets to insureds and their treating providers at different points in the appeals process. The new requirements are described in Circular Letter 2000-6, at p. 20, and summarized below.

New information: The information packets must: (1) advise the insured that the insured is not responsible for the cost of an external independent review; (2) advise the insured that the Department's consumer assistance unit is available to help the insured; (3) include the Department's consumer assistance phone number; and (4) include standardized forms (developed by the Department) that an insured can use to pursue an appeal.

Distribution: Insurers must send information packets: (1) at initial enrollment; (2) when the insured commences an appeal; and (3) upon request of an insured or treating provider. The insurer must also send a separate reminder notice at annual renewal. The insurer is no longer required to automatically send another copy of the information packet at formal appeal if the insurer already sent a packet when the insured filed for informal reconsideration. Packets need not be sent to a treating provider unless the provider requests a packet.

The Appeal Process

With the changes in the law, Arizona now effectively has two different forms of appeal: expedited and standard. Expedited appeals are for urgently needed services that an insured has not yet received. Standard appeals are for non-urgent services and denied claims. An insurer is not required to offer an expedited appeals process if its utilization review activities are limited to claims review for services already provided.

Each type of appeal has three levels, as follows:

	<u>Expedited</u>	<u>Standard</u>
Level 1.	Expedited Medical Review	Informal Reconsideration ³
Level 2.	Expedited Appeal ⁴	Formal Appeal
Level 3.	Expedited External Independent Medical Review	External Independent Medical Review

The two types of appeals operate in a similar fashion. The primary distinction is that the expedited appeal has much shorter time frames for each level.

² As noted throughout this circular, various provisions have different effective dates. Arguably, this requires insurers to have a different insurance packet for the time period from January 1, 2001 through March 1, 2001, than for the time period after March 1, 2001. The Department recognizes that this would be administratively burdensome for insurers and potentially confusing for consumers. For that reason, the model packets and forms appended to this circular reflect changes effective on and after March 1, 2001. Insurers must use the new packets on and after March 1, 2001.

³ Insurers are not required to provide informal reconsideration for denied payment of claims, although an insurer may elect to do so. A.R.S. § 20-2535(A).

⁴ This provision is effective January 1, 2001. On and after this date, insurers should process expedited appeal requests pursuant to the time frames for expedited appeals established in HB 2600.

Expedited Appeals Process (Effective January 1, 2001)

The new law revises the standard to qualify for the expedited process. An expedited appeal requires the insured's treating provider to certify in writing, and provide supporting documentation that the time needed to complete Levels 1 and 2 under the standard process (60 days) "is likely to cause a significant negative change in the [insured's] medical condition at issue [on appeal]." A.R.S. §20-2534(A). Previously, the provider had to certify that the time necessary to complete the informal reconsideration (a 30-day period) *could* cause a significant negative change in the insured's condition. The Department has created a physician certification form that treating providers may use when requesting expedited review. A copy of this certification form is enclosed with this Circular Letter as part of the revised health care appeals information packet. Insurers may not condition provision of an expedited appeal on use of this or any other specific form.

An insurer may not challenge the provider's certification or refuse to expedite an appeal if the provider makes the requisite certification and provides supporting documentation. The Department has received several complaints from insureds who alleged that their insurers were refusing to permit expedited review because the insurer did not feel that the case was of sufficient urgency. Such refusals are explicitly prohibited under the revised law.

If a provider or an insured asks for expedited review without submitting the required certification and supporting documentation, the health care insurer or utilization review agent (UR agent) may treat the case as a standard appeal. The Department recommends that the insurer or UR agent advise the insured and the provider of this change, and the reason for it, when sending the 5 day acknowledgement required under A.R.S. §20-2535(B) or A.R.S. §20-2536(B).

If the certification and supporting documentation are later provided, the insurer and UR agent must immediately treat the case as an expedited appeal from that point forward, and observe the time frames for the expedited process.

Similarly, if the insured or provider fails to observe time frames for action under the expedited process, the insurer may convert the case to a standard appeal, but cannot dismiss the appeal. The Department expects that insurers will act reasonably in converting a case. For example, upon receiving a denial at level 1, the provider may appeal to level 2 by "immediately" submitting the appeal. "Immediately" is not defined, but the Department interprets this requirement to mean expeditiously in light of the patient's medical condition. The provider and insured must have time to receive and review the decision, and to confer about the appropriate course of action.

Level 1: Expedited Medical Review (Effective January 1, 2001)

If the UR agent upholds the insurer's denial at this level, the insurer (or its UR agent) must now provide the insured and treating provider with telephonic as well as written notice of the denial and the right to immediately proceed to Level 2, an Expedited Appeal.

Level 2: Expedited Appeal (Effective January 1, 2001)

Following a Level 1 denial, A.R.S. §20-2534(E) allows the insured's treating provider to request an expedited appeal by immediately submitting a written appeal to the UR agent, along with any additional material justification or documentation supporting the request. The

UR agent has 3 business days after receipt of the appeal to notify the insured and the treating provider of the decision. Medical necessity decisions must be made by a licensed health care professional as described below. If the denial is upheld at this level, the insurer's UR agent must provide the insured and treating provider with telephonic and written notice of the denial and the right to immediately proceed to Level 3, Expedited External Independent Review.⁵

At Level 2, if the case involves a question of medical necessity, the insurer or its UR agent must select a licensed health care professional⁶ to review the appeal and make the decision. Registered nurses, pharmacists, technicians and therapists are not included in the list of licensed professionals who can render medical necessity appeals decisions at this level. Decisions involving coverage issues need not be rendered by a licensed health care professional. (Note: If a medical necessity case is appealed to Level 3, the insurer must advise the Department of the name and qualifications of the licensed professional issuing the Level 2 denial.)

UR Agent Option to Skip Levels 1 and 2

As under the standard appeal process, the UR agent, at any time, has the option of skipping Level 1 or 2, and immediately submitting a case for external independent review (Level 3). If the UR agent skips to Level 3, the UR agent need not comply with Level 2 requirements, but must send the insured and treating provider a written acknowledgment that the appeal was sent for Expedited External Independent Review.

Standard Appeals Process

Level 1: Informal Reconsideration

Other than the changes discussed above related to distribution of the information packets, the requirements for Level 1 (Informal Reconsideration) are unchanged.

Level 2: Formal Appeal

The changes to the requirements for distribution of the information packets (discussed above) also affect this level. Also, **effective January 1, 2001**, as under Level 2 of the expedited process, insurers must have a licensed health care professional (as that term is defined in A.R.S. §20-2536(D)) render a decision *only* for appeals of denials based on lack of medical necessity. Previously, insurers were required to have all Formal Appeal decisions (including contract coverage cases) decided by licensed health care professionals.

Level 3: External Independent Review Expedited and Standard Processes

Circular Letter 2000-6, pp. 20-22, includes a detailed discussion of the changes to the external independent review that occur at Level 3, including the different time periods applicable to expedited and standard appeals. This Circular Letter will address only procedural issues.

⁵ Expedited review at Level 3 is not effective until March 1, 2001.

⁶ Providers who qualify as "licensed health care professionals" are listed in A.R.S. §20-2534(E). Essentially, the statute requires that the reviewing provider be one who is qualified in a scope of practice similar to that of the treating provider, or one who typically manages the medical condition on appeal. Insurers should carefully review this statute to ensure that their process is consistent with statutory requirements.

Effective March 1, 2001, utilization review agents and health care insurers will no longer select the external independent reviewers for health care appeals and cannot send the appeals directly to an external independent reviewer. As of that date, the Department's previously published 2000-2001 list of external independent reviewers for health care appeals is void, and all external appeal requests must be sent to the Department of Insurance. **Any case that is submitted for external independent review after March 1, 2001 must be sent to the Department, even if the appeal was commenced at Level 1 or 2 prior to that date.**

The process for external independent review is the same for expedited and standard appeals except for the time in which decisions must be rendered. To request external independent review, an insurer (or the UR agent acting on its behalf) must send the Department all of the information listed below with a completed transmittal form.

1. The request for external independent review submitted by the provider or insured, and any pertinent correspondence between the enrollee, provider, and insurer.
2. The insured's policy, certificate, evidence of coverage, or similar document.
3. All medical records.
4. Supporting documentation used to render the decision.
5. Summary description of the applicable issues.
6. A statement of the utilization review agent's or insurer's decision.
7. The utilization review agent's or insurer's criteria used and any clinical reasons for the decision.
8. The relevant portions of the utilization review agent's utilization review plan.

If the appeal involves a question of medical necessity, insurers must send the Department **2 copies** of all items listed above. Failure to include all of the necessary materials can delay processing of an appeal and potentially result in civil penalty assessments.

On and after March 1, 2001, insurers must use Transmittal Form P-1098, Rev. 10/00, (copy attached) when sending the Department the materials listed above. After that date, the Department will not accept the prior version of the Transmittal Form P-1098. The new transmittal form includes space for the name and credentials of the health care provider who reviewed the case at the lower appeal level, as required under A.R.S. §20-2533(G).

Previously, A.R.S. §20-2537(l)(3) prohibited disclosure of the names of the insured and the treating providers in materials sent to the external independent reviewer. As of March 1, 2001, this requirement is repealed and materials sent to the Department should not have this information removed.

Procurement and Payment of Independent Review Organizations

The Department is required to procure independent review organizations (IROs) to conduct medical reviews of Level 3 appeals that involve questions of medical necessity. Through the State Procurement Office, the Department will procure a contract for IRO services. The contract will specify that:

1. A procured IRO must use appropriately licensed physicians and health care professionals who typically manage the medical condition, treatment, or procedure under review.
2. The IRO and its individual reviewers shall not have a substantial interest in the member, provider, or health care insurer involved in the particular case under review or any other conflict of interest that would prevent the reviewer from making a fair and impartial decision.
3. The individual medical reviewer cannot be a policyholder or insured member of the insurer whose decision is under review.

The Department will attempt to procure the services of IROs that accept compensation on a "per case rate."

A.R.S. §20-2540 establishes a health care appeals fund from which the Department will pay the costs billed for independent medical reviews performed by the IROs. The Department will recover from an insurer the cost of an independent medical review for an appeal originating from that particular insurer. The Department will provide more detailed information and guidance on the process and procedures for administration of the health care appeals fund when the fund becomes operational.

IV. HEALTH CARE APPEALS INFORMATION PACKET

Information Packet

The Department has revised the text of the sample information packet that insurers must provide to their insureds. A copy of the sample packet is attached to this Circular Letter. It reflects the changes in the process and the new information requirements. Insurers are not required to use the sample packet verbatim, but must use it as a guide in designing their own form. The Department encourages insurers to adhere closely to the sample packet so that the language and format will be readily familiar to consumers who may switch between different insurers and plans. Some insurers may wish to supplement the standard packet. The Department has approved packets with supplemental information that is specific to a particular insurer, or its product or members. An insurer must customize the forms by inserting the following specific information at the spaces designated in the packet:

1. Name of the health care insurer.
2. The titles, telephone and FAX numbers, and addresses of the contact person and processing person for the different appeals levels.

3. If an insurer allows insureds that are appealing denied claims to begin the appeals process at the Informal Reconsideration level, the insurer must modify the packet to include the appropriate information for processing those appeals. If the insurer requires insureds to begin at the Formal Appeal level, the insurer should omit the bracketed text from the model in the Informal Reconsideration section of the packet.

Insurers must file their **customized** packet with the Department's Life and Health Division for review and approval prior to use. Utilization review agents must use the insurer's approved packet, and cannot create their own packets.

Standardized Appeal Forms

The Department has also developed two standardized forms that consumers may use when pursuing an appeal. The standardized forms are: (1) an appeal request form, and (2) a physician certification. (copies attached). Insurers are required to include these forms with the information packet.

These forms are included as a convenience for insureds and providers. **Insurers may not mandate use of these forms, or reject an appeal because an insured or provider chooses not to use the standard forms.**

The information packet and forms are available on the Department's website www.state.az.us/id. After entering the website, click on Publications, from there, look under Information Brochures, and then under HealthCare Appeals Information Packet.

V. REGULATORY ENFORCEMENT ACTIONS TO DETERMINE COMPLIANCE

The Department will continue to audit health care insurers for compliance with Arizona's health care appeals laws. To date, some of the more common deficiencies identified through the audit process include:

1. Failing to distribute health care appeals information packets.
2. Delegating the processing of appeals to a third party, but failing to monitor the third party's performance to see that it is consistent with Arizona law.
3. Failing to include the criteria used and the clinical reasons for appeal decisions. Simply stating that a service or claim is "not medically necessary" or "not covered" is insufficient. The written appeal decision must include the policy and utilization review provisions that justify and explain the decision.
4. Requiring insureds to go through two formal appeals rather than having the case sent for external independent review.
5. Failing to send written acknowledgements to the member and treating provider within 5 business days of receiving the appeal.
6. Rejecting appeal requests that originate with the provider.
7. Failing to render appeal decisions within statutory time frames.
8. Treating appeal requests as "complaints" or "grievances" not subject to the health care appeals process, rather than as appeals.

9. Processing appeals differently than indicated in the insurer's health care appeals information packet. For example, some insurers' packets require an insured to initiate an appeal of a denied claims payment at the formal appeal level. This would result in only one internal appeal at the insurer, as external independent review is the next step after formal appeal. In practice, however, the insurer treats the initial appeal as an informal reconsideration, and subjects the insured to two levels of appeal at the insurer.
10. Suspending all action on an appeal request if the request does not include medical records or other supporting documentation. This is not permissible. A.R.S. §20-2535 expressly permits an insured to orally request an appeal. The Department expects insurers to comply with the specific time requirements in A.R.S. §§20-2535 and 20-2536 and regards insurers as having an affirmative duty to advise the insured if supporting documentation or records are required for the insurer to fairly evaluate the appeal. A UR agent may hold an appeal open pending the receipt of any requested additional information. However, if the insured or treating provider fails to submit the requested information within the statutory time frame, the UR agent must still issue a timely decision based on all other available information. A decision that is based on lack of information should so specify. If the insured or provider submits the requested information after a decision is rendered, the insurer must treat the new information as a request for appeal to the next level.

Maintenance of Appeals Files

The Department is required to publish an annual report on Arizona's health care appeals. To gather information required for this report, the Department sends insurers an annual survey on health care appeals, and particularly seeks information on the number and outcomes of appeals conducted at Levels 1 and 2. To provide this information, insurers must track and maintain complete files of all health care appeals received and processed. These files must also be maintained in order to facilitate examinations. The Department recommends that insurers maintain complete appeals files for at least 3 years following issuance of the final case decision, at whatever level that decision occurs.

Please direct any questions regarding this Circular Letter to Elise Bartlett, Supervisor of the Health Care Appeals Section at (602) 912-8443.

Health Care Insurer Appeals Process Information Packet
[Insurer Name]

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process
Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our customer/member services number at _____ to ask.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department (“the Department”) developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department’s Consumer Assistance Office at (602) 912-8444 or 1-(800) 325-2548 or call us at _____.

How to Know When You Can Appeal

When [*name of insurance company* or “we”] do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not “medically necessary.”
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of “usual and customary charges.” [*Insurers may wish to insert their definition of UCR when customizing their packets.*]
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th, Second Floor, Phoenix, AZ 85018.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient’s condition.

	<u>Expedited Appeals</u> <u>(for urgently needed services</u> <u>you have not yet received)</u>	<u>Standard Appeals</u> <u>(for non- urgent services or denied</u> <u>claims)</u>
Level 1.	Expedited Medical Review	Informal Reconsideration ¹
Level 2	Expedited Appeal	Formal Appeal
Level 3	Expedited External Independent Medical Review	External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

¹ Many insurers do not provide informal reconsideration of a denied claim; the insured begins at the formal appeal level. Those insurers can include a footnote to specify that informal reconsideration is not available for a denied claim.

**EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES
NOT YET PROVIDED**

Level 1. Expedited Medical Review

Your request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us,
- We denied your request for a covered service, and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Name:
Title:
Address:
Phone:
Fax:

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within that same business day, we must call and tell you and your treating provider, and mail you our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider *must immediately* send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2. To help your appeal, your provider should also send

us any more information (that the provider hasn't already sent us) to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have only 5 business days after you receive our Level 2 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Name:
Title:
Address:
Phone:
Fax:

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent reviewer organization (the “IRO”).

Within 5 business days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO’s decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review, your policy, evidence of coverage or similar document, all medical records and supporting documentation used to render our decision, a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS
--

Level 1. Informal Reconsideration

Your request: You may obtain Informal Reconsideration of your denied request for a service [or claim]² if:

- You have coverage with us,
- We denied your request for a covered service [or claim],
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service [or claim] by calling, writing, or faxing your request to:

Name:	Phone:
Title:	
Address:	Fax:

Claim for a covered service already provided but not paid for: You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal.

{If the insurer permits Informal Reconsideration of a claim for a covered service that has already been provided, delete the paragraph above and include the bracketed language in this section that references claims.}

Our acknowledgement: We have 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that we got your request.

² Bracketed text [] should be included if the insurer allows informal reconsideration of a denied claim payment.

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service [or pay your claim]. Within that same 30 days, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have 60 days to appeal to Level 2.

If we grant your request: The decision will authorize the service [or pay the claim] and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request Formal Appeal if: (1) we deny your request at Level 1, or (2) you have an unpaid claim and we did not provide a Level 1 review. After you receive our Level 1 denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level 2. If we did not provide a Level 1 review of your denied claim, you have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Name:

Phone:

Title:

Address:

Fax:

Our acknowledgement: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: For a denied service that you have not yet received, we have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, we have 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request or claim: You have 30 days to appeal to Level 3.

If we grant your request: We will authorize the service or pay the claim and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have 30 days after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Name:	Phone:
Title:	
Address:	Fax:

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (IRO), procured by the Arizona Insurance Department, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Insurance Director must send all the submitted information to an external independent review organization (the “IRO”).

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business days of receiving the IRO’s decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO’s decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director’s final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings (“OAH”). If we disagree with the Director’s determination of coverage issues, we may also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires “any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed” by law. This means, that for appealable decisions, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

[Insurers may insert an address block directing insureds to submit this form to a specific address.]

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name _____ Member ID # _____
Name of representative pursuing appeal, if different from above _____
Mailing Address _____ Phone # _____
City _____ State _____ Zip Code _____

Type of Denial: Denied Claim Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 912-8444 or 1-(800) 325-2548, or [name of insurer] at _____.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Medical records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) ****Also attach the certification from your treating provider if you are seeking expedited review.**

Signature of insured or authorized representative

Date

[Insurers may insert an address block directing providers to transmit this form to a specific location.]

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) “is likely to cause a significant negative change in the [patient’s] medical condition at issue.”

PROVIDER INFORMATION

Treating Physician/Provider _____		
Phone # _____	FAX # _____	
Address _____		
City _____	State _____	Zip Code _____

PATIENT INFORMATION

Patient’s Name _____		Member ID # _____
Phone # _____		
Address _____		
City _____	State _____	Zip Code _____

INSURER INFORMATION

Insurer Name _____		
Phone # _____	FAX# _____	
Address _____		
City _____	State _____	Zip Code _____

- Is the appeal for a service that the patient has already received? Yes No
If “Yes,” the patient must pursue the standard appeals process and cannot use the expedited appeals process.
If “No,” continue with this form.
- What service denial is the patient appealing? _____

- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____

Attach additional sheets if needed, and include: Medical records Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 912-8444 or 1 (800) 325-2548. You may also call [name of insurer] at _____.
--

I certify, as the patient’s treating provider, that delaying the patient’s care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient’s medical condition at issue.

Provider’s Signature _____ Date _____

STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

Is this an Expedited External Independent Review Request? <input type="checkbox"/> Yes <input type="checkbox"/> No
This case is a denial based on: <input type="checkbox"/> lack of medical necessity <input type="checkbox"/> a coverage issue

Insured Member's Name _____
Mailing Address _____
City, State, Zip Code _____
Insured's Telephone # _____ Member I.D. # _____

Insurer's Name _____
Insurer NAIC # _____
Insurer's Street Address _____
City, State, Zip Code _____
Telephone # _____ FAX # _____
Contact Person Name and Phone no. _____

Treating Provider's Name _____
Office Address _____
Mailing Address, if different than above: _____
City, State, Zip Code _____
Provider's Telephone # _____ FAX # _____
Treating Provider's Medical Specialty _____
(If multiple providers, please list other providers on reverse)

Utilization Review Agent _____
UR Agent's Street Address _____
City, State, Zip Code _____
UR Agent Telephone # _____ FAX # _____
Contact Person _____

External Review requested by: insured member insurer UR Agent Az D O I
Date External Review requested _____ Date of Level 2 Decision _____
Decision to deny or not authorize service or claim was made by:
 Insurance Company Health Care Services Org. UR Agent
For medical necessity cases: Name(s) and credentials of provider(s) issuing the level 1 & 2 decisions:

- With this form, transmit all items listed below. **For medical necessity cases, submit 2 copies** of all items.
1. Copy of the insured's policy, certificate, evidence of coverage or similar document
 2. All medical records
 3. Supporting documentation used to render the decision
 4. Summary description of the applicable issues
 5. A statement of the utilization review agent's or insurer's decision
 6. The utilization review agent's or insurer's criteria used and the clinical reasons for the decision
 7. The relevant portions of the utilization review agent's utilization review plan
 8. The insured's or provider's letter or appeal form requesting the appeal, and all pertinent correspondence between the member/enrollee and the insurer.